

REQUEST FOR APPLICATION

Fiscal Year 2002-2003

Application Materials



**Indian Health Program
Primary and Rural Health Care Systems Branch
Primary Care and Family Health Division
California Department of Health Services
714 P Street, Room 599
Sacramento, CA 95814**

March 2002

**CALIFORNIA STATE INDIAN HEALTH PROGRAM
REQUEST FOR APPLICATION (RFA)
FY 2002-2003
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Indian Health Program (IHP)**Fiscal Year 2002-2003****Request for Application (RFA)****Application Review and Grant Processing Schedule**

Application Mailed to Potential Grantees	March 12, 2002
Grantee Notification of Tentative Award Amount	April 5, 2002
Application Final Submission Deadline	April 12, 2002
Application Review by IHP Staff	April 12 – 26, 2002
Grant Mailed to Grantee for Signature	May 24, 2002
Signed Grant Returned	June 7, 2002
Grant Funds Encumbered	July 1, 2002

NOTE: These are estimated dates, which are subject to change.

**STATE INDIAN HEALTH PROGRAM (IHP)
REQUEST FOR APPLICATION (RFA)
FISCAL YEAR 2002-2003**

I. PURPOSE

The purpose of this RFA is to announce the availability of funds from the Department of Health Services (DHS) for American Indian health programs to provide comprehensive primary care services in a culturally competent manner. Funds are available from July 1, 2002 to June 30, 2003, subject to the final appropriation in the state budget.

II. FUNDING ELIGIBILITY

To qualify for funding, an Indian health program shall be administered by a non-profit corporation organized under the laws of this State or by an Indian tribe. The board of directors or trustees of such corporation shall be composed of a majority of Indians. (California Code of Regulations, Title 17, Section 1534).

Indian Tribe: "Indian Tribe" means any Indian Tribe, band, or nation or other organized group or community, which is determined to be eligible for the special programs and services provided by the United States or State of California to Indians because of their status as Indians. (California Code of Regulations, Title 17, Section 1501).

III. APPEALS

Each application received by IHP by the specified date and time will be reviewed for completeness and compliance with the RFA instructions. Late, incomplete or non-compliant applications may be rejected. The DHS may waive any immaterial deviation in any application. This waiver of any immaterial deviation shall not excuse an applicant from full compliance with the grant terms if a grant is awarded. The DHS reserves the right to negotiate the terms and conditions of all awards, including the amount of funding. The DHS reserves the right to reject any or all applications, as well as to make the final selection of applicants for funding. Applicants can appeal award decisions in writing by specifying the basis for the protest and the remedy sought. There is no appeal for untimely or incomplete applications, or of the amount of the award. Appeals must be postmarked no later than fifteen working days from the date of a denial notice or other action being grieved. Mail appeals to:

Ms. Sandra Willburn, Acting Chief
Primary and Rural Health Care Systems Branch
Department of Health Services
714 P Street, Room 550
P.O. Box 942732
Sacramento, CA 94234-7320

If necessary, the IHP will arrange for an administrative hearing pursuant to the "Grievance

Procedure for Direct Service Contracts and Grants” outlined in 9-2350 of the Health Administrative Manual.

IV. BACKGROUND

The IHP is authorized by California Health and Safety Code, Sections 124575 -124595. The goal of the IHP is to improve the health status of American Indians residing in California. This is accomplished through the provision of financial and technical assistance to Indian health programs, studies of the health and health services available to American Indians and their families, and coordination with similar private and governmental programs.

V. SERVICES TO BE FUNDED

The State Indian Health Program funds Indian health programs that contain the following components (these components are not necessarily in priority order or all-inclusive):

A. Administration: The orderly planning, organizing, and coordinating of a health program to effectively carry out a grantee’s obligations. This shall include but not be limited to, the following specific elements:

1. A Board of Directors that is representative of the American Indian community.
2. A qualified administrator with appropriate background demonstrating sound managerial abilities and experience.
3. Personnel management policies.
4. Appropriate facilities.
5. Fiscal management and billing procedures, including a fiscal reporting system; provisions for annual audit, maintenance of accounts.
6. Planning and evaluation components; integration and coordination of all program activities.

B. Direct Medical Services: The provision of a prevention-oriented health care program which shall provide, but shall not be limited to, the following specific components:

1. Comprehensive history and physical examinations.
2. Diagnosis, treatment, and follow-up of illnesses and diseases.
3. Health maintenance activities.
4. Minor surgery and emergency medical services.
5. Prenatal and postpartum services.
6. Family planning services.
7. Children's services (consistent with Child Health and Disability Prevention Program (CHDP) medical guidelines).
8. Referral services.
9. Health education.
10. Nutrition services.

C. Dental Services: The provision of a comprehensive public health oriented dental

program, which includes the planned and supervised delivery of preventive and restorative dental services.

- D. Community Health Services:** The provision of a program which identifies American Indians in the grantee service area and assists them to achieve optimum physical and emotional well-being by providing them with information and assistance in entering and using health systems and health resources appropriately. The scope of services includes identifying American Indians within the service area; identifying and documenting the health and socioeconomic needs of members of the American Indian community; assisting the American Indian population to enter the health system through health education, case finding, counseling, referrals, and follow-up; assisting American Indians in learning to use health and social service resources appropriately; providing health education to promote healthy life styles; assisting American Indians in improving their health status by providing appropriate health instruction and personal care; developing liaisons with resource agencies, providers, and schools; assisting American Indians in clarifying issues which may prevent utilization of health resources; participating in identifying and planning needed resources for the continued improvement of health services to the American Indian community; maintaining accurate records of patient services.
- E. Traditional Medicine:** The provision of traditional Indian medicine, which includes practices which are native to an Indian community and which are accepted by that Indian community, as handed down through the generations and which can be established through the collective knowledge of the elders of that Indian community.

Some examples of activities recognized as appropriate for State funding include:

1. Funding of local Traditional Indian Health Advisory Committees.
2. Travel and related costs for use of medicine men and women and doctoring.
3. Traditional Indian health gatherings.
4. Educational cultural sensitization activities for non-Indian/Indian health personnel.
5. Costs associated with gathering or purchasing herbs, teas, or other healing elements used in traditional practices.

VI. MINIMUM APPLICATION REQUIREMENTS

In addition to "Funding Eligibility" described in Section II above, to qualify for funding, applicants shall demonstrate administrative competency. At the time of application applicants shall:

- A.** Directly provide a combination of community health program, medical, and dental services as described in Section IV ("Services to be Funded"), to American Indians in rural and/or urban areas of California. Health programs must maintain service delivery at least 24 hours per week for at least two (2) of the three (3) direct service components referenced above (medical, dental, community health).

- B. Be in good standing with the Office of the Secretary of State and the Office of the Attorney General if a Non-profit Corporation (if applicable).
- C. Tribal government must maintain good standing with the Bureau of Indian Affairs (if applicable).
- D. Maintain governing boards which meet regularly and function in accordance with their bylaws.
- E. Conduct annual Certified Public Accountant (CPA) Audits.
- F. Maintain third-party billing system (Title 17, Section 1533).
- G. Maintain an adequately staffed facility.
- H. Maintain clinic licensure or certification for all sites.
- I. Maintain a clinic pharmacy permit (if applicable).
- J. Maintain Clinical Laboratory Improvement Act (CLIA) State registration.
- K. Maintain liability and malpractice insurance in sufficient amounts to meet current state requirements.

VII. FISCAL YEAR (FY) 2002/2003 AWARD AMOUNTS

Notification by State staff of grantee IHP award amounts for FY 2002/2003 is tentatively scheduled for April 12, 2002. Grantees will be notified via telephone, FAX, and letter. Funding amounts to Indian health clinic grantees are determined through the use of an allocation formula (Health and Safety Code, Section 124585). The Allocation Formula consists of the following factors, which are weighted according to relative importance.

A. Foundational Criteria (22 %): The funds provided in this factor are distributed in equal portions to each Indian health grantee if they have a medical, dental, and outreach component providing patient care. To qualify for any IHP funding, a clinic must have at least two of these three components. If any of the three components are not provided, the following percentages are applied as deductions to the equal portion:

Medical: 40% Dental: 30% Community Health Services (Outreach): 30%

B. **Systems Appraisal (46 %):** The Systems Appraisal is the in-depth, on-site program evaluation of the quality of a clinic's medical, dental, community health services (outreach), and board/administrative/fiscal components. The programs are ranked based on their scores in each of these components. Funding levels are based on ranks achieved in each of the four areas noted above.

C. **Grant Objectives (15 %):** This factor assesses how well grantees have met the numerical objectives in their grants (patient visits). Data on grant objectives is taken from the most recently completed state fiscal year. In order to receive credit for an objective, the grantee must meet it by 100%. To calculate funding levels, all qualifying objectives from all clinics are added together. The resulting figure is divided into the amount of dollars that are distributed in this factor.

D. **Population Service Index (15 %):** The count of the number of Indian people served in one calendar year in both the medical and dental programs is taken from the unduplicated patient count from the Monthly Progress Reports submitted by grantees. The per capita dollar amount is calculated based on the statewide total of the Indian patients served in a year in the clinic medical and dental programs and the amount of funds allocated for this factor. A per capita figure is then multiplied by the number of Indians each grantee served in order to arrive at the funds awarded for this factor.

E. **Target Population (2%):** This factor indicates the need for services based on the number of American Indians living in geographical service areas as determined by the U.S. Indian Health Service. Calculation of this factor involves determining a statewide per capita figure and then multiplying this figure by each grantee's target population within their service area.

VIII. GRANTEE REQUIREMENTS

- A. Comply with all provisions of the grant including, but not limited to, provisions of the quality and quantity of the direct and subcontracted services specified to the population(s) targeted.
- B. Notify the State Indian Health Program in a timely manner regarding any situation that would substantially alter the grantee's ability to comply with grant obligations.
- C. Comply with all reporting requirements described in the grant agreement.
- D. Participate in relevant evaluation and monitoring activities as determined by the State to identify levels of grant compliance and need for consultation/technical assistance.
- E. Participate in technical assistance activities identified as needed by the state including, but not limited to, workshops, conferences, individual assistance, etc.

- F. Assure that community and/or clients participate in the development of policies and procedures on an ongoing basis (through their governing Board of Directors).
- G. Carry out the provisions of the grant and ensure that all subcontractors carry out the provisions of the grant in the most cost-effective and cost-efficient manner possible.
- H. Comply with, and ensure all subcontractors comply with, all governmental laws and regulations appropriate to the operation of a primary health care program.
- I. Provide services in a culturally competent manner.

IX. ADVANCE PAYMENTS

Potential Indian Health Program grantees may be eligible to receive an advance payment not to exceed 25% of the total award amount (Section 124410 of the Health and Safety Code).

- A. Criteria to be considered in granting advance payments include status of FY 2001-2002 invoices (must be current); FY 2000-2001 Certified Public Audit submittal; status of FY 2001-2002 Indian Health Program Monthly Progress Reports (must be current); current quarterly or monthly financial report; etc.
- B. Applicants are required to repay advance payments in full if the grant is not approved.
- C. A letter with procedural instructions for requesting advance payments will be forwarded to IHP grantees in July 2002.

X. INSTRUCTIONS FOR COMPLETING APPLICATION FORMS

A. APPLICATION COVER PAGES (Pages 14 - 16)

Please complete all items listed on the application cover pages. **The proposal will be returned unprocessed** if the original signatures of the Board Chairperson, Program Administrator, and Fiscal Officer are missing. If any of these positions are currently vacant, the board must authorize in writing an acting individual to perform the functions of the vacant position (please attach copy of authorization).

B. ELIGIBILITY REQUIREMENTS (Page 17)

- List all of your current Board members including their address, telephone number, position on the board (Chairperson, Treasurer, member, etc.), tribal affiliation, employer, and information regarding their term dates.
- Submit copies of tax forms including the most recent Federal F-990 and State F-199 and CT2 forms or extension requests. Tribal programs that are exempt from these filings must submit copies of federal and state documents so indicating these exemptions.

C. MINIMUM APPLICATION REQUIREMENTS (Pages 18 - 19)

- Provide Medi-Cal and Denti-Cal billing information including clinic provider and individual provider numbers (provider's license must be current) and all corresponding service site numbers and provider names. Also required is a copy of an agreement that states that income derived from billing under the provider's number is the clinic's income (if applicable).
- Submit the program's most current monthly or quarterly financial statement.
- As required by Title 17, Section 1503, provide the clinic's license or certification number with expiration date, pharmacy permit/certificate (if applicable), Clinical Laboratory Improvement Act (CLIA) certificate or a waiver (if applicable) with expiration dates, a copy of applicable insurance coverage, and a listing of all licensed health personnel including their name, the type of license, their license number and date their license expires. **The proposal will be returned unprocessed** if the information is not provided and the documents referenced are not submitted.

XI. INSTRUCTIONS FOR COMPLETING BUDGET TABLES (Tables A , B, and C)

Enter your program name at the top of each table. If necessary, add additional pages by repeating your program (Agency) name, budget table title, and next page number(s) on a blank page.

Round all amounts to whole numbers.

Please be accurate as inaccuracies may result in unnecessary delays. Check tables for accuracy by:

Adding each line item horizontally.

Adding each source of funds column vertically.

Adding horizontal total column to reach a grand total.

Adding vertical total column to reach a grand total.

(Note: the horizontal and vertical grant totals should agree).

Having another individual check your figures.

Unreimbursable Expenses: The Department of Health Services does not reimburse several types of expenses; therefore, the following list of expenses cannot be funded in your IHP budget:

-Purchase, renovation, alteration, or improvement of contractor owned or leased property (real estate) or facilities.

-Contract care as defined by Federal Indian Health Services Regulations.

Table A: Summary of Current Budget from all Sources (Page 20): List each funding source and the total funds awarded by personnel, operating expenses, and consultants. If your funds are not on a July to June fiscal year, please *estimate*, as close as possible, the amount for this July to June period.

Table B: Current Personnel Budget from all Sources (Page 21): List each personnel services position in your program. List position title (not individual name) and dollar amount per line by source of funds (State, Federal, Third Party, etc.).

Table C: Proposed IHP Budget (Line Item Budget), (Pages 22 - 23):

Table C - Personnel Services:

List position title rather than the name of the individual. Please include job descriptions for ***all*** "Personnel Services line items" proposed for funding by IHP not funded by IHP in the prior fiscal year, FY 2001-2002 (Table C).

- **Column A:** The "FTE Salary Per Pay Period". Full-time Equivalent or FTE is the rate of pay an individual would earn if their time base was 100%. The figure to be entered in this column can be determined by (a) calculating the annual amount the individual would earn as an FTE, and (b) then by dividing this annual amount by the number of pay periods during the grant period.
- **Column B:** Indicate the "Number of Pay Periods" there will be for the period July 1, 2002 to June 30, 2003, e.g., 12, 24, 26.
- **Column C:** The "Percent of FTE" worked by the individual is based on a 40-hour workweek. This is the total time the individual works at your program regardless of funding source (see below).

<u>Hours Per Week</u>	<u>Percent of FTE</u>	<u>Hours Per Week</u>	<u>Percent of FTE</u>
4	10	24	60
8	20	28	70
12	30	32	80
16	40	36	90
20	50	40	100

- **Column D:** The "Percent Paid by This Grant". Determine the percent of annual salary budgeted that will be paid by this grant.
- **Column E:** The "Amount Requested". Columns A x B x C x D must multiply across and agree with the amount listed in this column (E).
- **Fringe Benefits** – Indicate the percentage of Personnel Costs used to calculate fringe benefits. List fringe benefits (i.e. FICA, SUI, WC). If the "fringe benefit" rate is above 30 percent, please provide justification.

Table C - Operating Expenses:

- **Audit:** Audits carried out pursuant to Health and Safety Code, Sections 38040 and 38041 shall be audits of the grantee, rather than audits of individual grants or programs. Audits shall be in accordance with OMB Circular A-133 "Single Act Audits" for contractor receiving \$300,000 or more of federal dollars. In the case of any contractor that receives less than twenty-five thousand dollars (\$25,000) per year from any state agency, the audit required by these Health and Safety Code sections shall be conducted biennially, unless there is evidence of fraud or other violation of state law in connection with the direct service contract. The cost of such audit may be included in direct service contracts up to the proportionate amount that the contract represents of the contractor's total revenue (e.g., if total funds are \$1,000,000 of which state funds represents \$100,000, the contractor may budget 1/10 of the \$100,000 amount or \$10,000 in the state budget because \$100,000 is 1/10 of \$1,000,000).
- **Communications:** May include telephone, postage, advertising, and answering service.
- **General Expense:** Purchase of books, magazines, publications, and subscriptions; expendable office supplies; shipping costs; memberships and dues; expendable equipment (less than \$5,000 and/or having a life expectancy of less than one year); equipment maintenance, rental, and repair; installation costs; printing expenses; pre employment physicals.
- **Insurance:** All types/classes of insurance including liability and malpractice.
- **Janitorial/Maintenance Services:** Housekeeping and cleaning services, water cooler, copy machine maintenance (does not include rent), routine minor repairs for electrical, plumbing, or building facilities.
- **Patient Transportation:** Expendable vehicle expenses (gasoline and oil) incidental to the transportation of clinic patients for program-related business. Include patient transportation expenses incurred by outreach workers, public health nurses (PHNs), and/or community health representatives (CHRs) for transporting clinic patients. A vehicle mileage log shall be maintained on file by each staff member to document the date(s) and miles traveled.
- **Rent:** List number of square feet, cost per square foot, cost per month, and percentage of state share.
- **Technical Supplies:** Expendable medical, laboratory, X-ray, pharmaceutical supplies, and expendable equipment (equipment less than \$5,000 and/or a life expectancy of less than one year).
- **Traditional Health / Medicine:** Travel and related costs for use of medicine men and women, doctoring, traditional Indian health gatherings. Educational, cultural sensitization activities for non-Indian/Indian Health personnel.

- **Travel:** Grant funded staff or board member mileage and per diem not to exceed State Department of Personnel Administration rates.

Mileage: The standard rate is 31 cents per mile. The maximum private vehicle mileage reimbursement cannot exceed 31 cents per mile with written certification (on file with the employee's travel claim) that "the costs of vehicle operation were equal to or greater than the amount claimed".

Per Diem: \$124 for each 24 hours of travel -- if on travel status less than 24 hours, only actual per diem expenses may be reimbursed. Additionally, no lunch or incidental allowance may be reimbursed when employees are on travel status less than 24 hours.

Lodging:

\$84.00 plus tax with receipt for most counties.

\$110 plus tax with receipt for the following counties:

Alameda, San Francisco, San Mateo, Santa Clara, and Central and Western Los Angeles. Central and Western L.A. are designated by the boundaries of Sunset Blvd on the North, the Pacific Ocean on the West, Imperial Blvd/Freeway 105 on the South, and Freeways 110, 10, and 101 on the East.

Meals:

Breakfast \$6.00 (actual cost up to \$6.00 with receipt)

Lunch \$10.00 (actual cost up to \$10.00 with receipt)

Dinner \$18.00 (actual cost up to \$18.00 with receipt)

Incidentals \$6.00

- **Utilities:** Electricity, gas, water, sewer, and garbage service.
- **Vehicle Operation and Maintenance:** Minor and major vehicle repair and maintenance, tires, batteries, license fees, and registration.

Table C - Capital Expenditures (Equipment):

Equipment expenses for items with a dollar value of \$5,000 or more and a life expectancy of one year or more. Include the unit cost of each item and the total cost (number of units multiplied by the unit cost). Equipment is subject to state inventory guidelines.

Table C – Other Costs:

- **Consulting and Professional Services:** Grant-related services performed by "independent contractors" as defined by Title 22, Division 2.5, Section 4304.1 (Employment Development Department) who are not employees of the grantee. Fees for audit, administrative, medical, and/or dental consultation or referral services such as laboratory and X-ray. See attached Exhibit C, Provision 10, for subcontract/consultant governing provisions. List each consultant, the rate of dollars per hour, and the subcontract amount.
- **Staff Training and Continuing Education:** May include tuition, registration, and material for continuing education classes, books/periodicals related to employee job duties, or health-related information only. May include expenses related to seminars, meetings, and conferences if related to program activities.

Table C - Indirect Costs:

Expenses incurred for the benefit of the business as a whole and which cannot be readily identified with the activities of a given department/program. Indirect costs must be those identified in the current "Indirect Cost Pool and Rate Computation" exhibit authored by the Office of the Inspector General, United States Department of the Interior or Department of Health and Human Services. **A copy of the "indirect cost" document must be submitted with the application. If used, the percent and cost basis must be explicitly specified in the budget submitted.**

XII. ADDITIONAL REQUIRED FORM

The following form is to be completed and inserted after the budget tables:

- Authorization to Bind Corporation and Invoice Approval Form

XIII. SUMMARY OF DOCUMENTS REQUIRED FOR SUBMITTING A COMPLETE RFA
(Extra copies of some of the forms below are available along with this RFA on the Indian Health Program website: www.dhs.ca.gov/ihp).

Documents required for completion and submission to be **RECEIVED** no later than April 12, 2002 are:

1. Pages 14 through 23 (Application Cover Pages, Eligibility Requirements, Minimum Application Requirements, Table A, Table B, and Table C).
2. Any additional pages where space for existing information needed is not sufficient.
3. Job descriptions for **all** "Personnel Services line items" proposed for funding by IHP not funded in the prior fiscal year, FY 2001-2002 (Table C).
4. If billing under physician(s)/dentist(s) provider number, a copy of the written agreement that any income derived from billing under the physician(s)/dentist(s) provider number is clinic income.
5. Authorization to Bind Corporation and Invoice Approval Form.
6. A copy of your most recent quarterly or monthly financial statement that includes all corporate debts and incoming funds.
7. A copy of your most recent Federal F-990, State F-199, and CT 2 tax forms or a Request for an Extension for filing (Federal form 2758 and State form 3504). If you are a tribe and exempt from taxation submit a copy of the documents submitted to Federal and State tax offices.
8. Copy of all clinic licenses / certifications.
9. Copy of pharmacy permit, if applicable.
10. Copy of CLIA registration.
11. Evidence of malpractice insurance.
12. A listing of the Board of Director meeting dates for the past 12 months.

XIV. MAILING ADDRESS

An original and one (1) copy of the application and budget must be received by April 12, 2002 at the following address:

**Department of Health Services
Indian Health Program
714 P Street, Room 599
Sacramento, CA 95814**

CALIFORNIA STATE INDIAN HEALTH PROGRAM (IHP) FY 2002-2003

FUNDS PROPOSAL - COVER PAGE 1

1. Agency Name:

Funding Amount:

2. Board Chairperson:

Signature:

(Please Type or Print Name Above)

Date:

Program Administrator:

Signature:

(Please Type or Print Name Above)

Date:

E-Mail Address:

Fiscal Officer:

Signature:

(Please Type or Print Name Above)

Date:

E-Mail Address:

3. Main Clinic Address: _____

Located on Reservation / Rancheria: ☐ Yes ☐ No

Days & Hours of Operation: _____

☐ State Licensed ☐ Medi-Cal Certified

Services Provided: _____

Telephone/FAX Numbers: _____

County(s) Served: _____

CALIFORNIA STATE INDIAN HEALTH PROGRAM (IHP) FY 2002-2003
FUNDS PROPOSAL - COVER PAGE 2

4. Additional Site(s) of Services (Use additional pages if necessary)

Address: _____
Located on Reservation / Rancheria: <input type="checkbox"/> Yes <input type="checkbox"/> No
Days & Hours of Operation: _____
<input type="checkbox"/> State Licensed <input type="checkbox"/> Medi-Cal Certified
Services Provided: _____
Telephone/FAX Numbers: _____
County(s) Served: _____

Address: _____
Located on Reservation / Rancheria: <input type="checkbox"/> Yes <input type="checkbox"/> No
Days & Hours of Operation: _____
<input type="checkbox"/> State Licensed <input type="checkbox"/> Medi-Cal Certified
Services Provided: _____
Telephone/FAX Numbers: _____
County(s) Served: _____

5. Clinic is a: ☐ Public Law 94-437 contractor ☐ Public Law 93-638 contractor

6. Corporate fiscal year dates: _____

7. Anticipated date of next fiscal audit: _____

CALIFORNIA STATE INDIAN HEALTH PROGRAM (IHP) FY 2002-2003

FUNDS PROPOSAL COVER PAGE - 3

(Agency's Name)

8. Please indicate governance structure:

- _____ Community Nonprofit Board as filed with the Secretary of State / Office of the Attorney General
_____ Tribally Authorized Charter for Health Program
_____ Tribal Council Self Governance

9. Provide a brief narrative summary describing your health program (no more than two pages) including any changes or improvements since the last contractual period.

10. List the names of reservations or rancherias in the service area and indicate contracting status:

Reservation / Rancheria (List)	Included in Clinic Service Population (Yes or No)	Administers Own Contract Service Funds (Yes or No)

11. Medicaid / Medicare provider type (please check)

- _____ FQHC
_____ IHS / HCFA MOA
_____ Fee For Service

12. Healthy Families Program contractor

☐ Yes ☐ No

Healthy Families contracting plans:

13. Managed Care contractor

☐ Yes ☐ No

Managed Care contracting plans:

CALIFORNIA STATE INDIAN HEALTH PROGRAM (IHP) FY 2002-2003

ELIGIBILITY REQUIREMENTS

(Agency's Name)

1. List Board of Directors (Attach additional pages if needed)

Board Member Address / Telephone Number	Elective Position and Employer	Tribal Affiliation	Specific Day / Month / Year Term Commences & Expires

2. List dates of regularly scheduled board meetings for the past twelve months.

- 3. Nonprofit / Tribal Status:** Submit a copy of your most recent Federal F-990 and State F-199 and CT2 tax forms that your program has submitted to the State / Federal tax offices. If you have submitted a Request for Extension for Filing (i.e., Federal tax form 2758 and/or State form 3504) these forms should be submitted. If you are a Tribe and Exempt from taxation, submit a copy of the documents submitted to the Federal and State tax offices.

CALIFORNIA STATE INDIAN HEALTH PROGRAM (IHP) FY 2002-2003
MINIMUM APPLICATION REQUIREMENTS PAGE 1

(Agency's Name)

1. Billing Authorization (Attach additional pages if needed.)

A. Indicate the clinic provider number for EACH service site certified for Medi-Cal and/or Denti-Cal billing:

Medi-Cal Clinic Provider Number(s):

_____	_____
Number	Service Site
_____	_____
Number	Service Site
_____	_____
Number	Service Site
_____	_____
Number	Service Site

Denti-Cal Clinic Provider Number(s):

_____	_____
Number	Service Site
_____	_____
Number	Service Site
_____	_____
Number	Service Site
_____	_____
Number	Service Site

B. If you are billing under your physician's and/or dentist's provider number, indicate the following:

_____	_____
Provider Number	Provider Name and Title
_____	_____
Provider Number	Provider Name and Title
_____	_____

Pharmacy Number(s), if applicable:

_____	_____
Provider Number	Provider Name and Title

FOR EACH PROVIDER LISTED ABOVE, SUBMIT A COPY OF THE WRITTEN AGREEMENT WHICH STATES THAT ANY INCOME DERIVED FROM BILLING UNDER THE PHYSICIAN / DENTIST NUMBER IS CLINIC INCOME.

2. Financial Status: Submit a copy of most recent quarterly or monthly financial statement that includes all corporate debts and incoming funds.

CALIFORNIA STATE INDIAN HEALTH PROGRAM (IHP) FY 2002-2003
MINIMUM APPLICATION REQUIREMENTS PAGE 1

(Agency's Name)

1. Billing Authorization (Attach additional pages if needed.)

A. Indicate the clinic provider number for EACH service site certified for Medi-Cal and/or Denti-Cal billing:

Medi-Cal Clinic Provider Number(s):

Number	Service Site
Number	Service Site
Number	Service Site
Number	Service Site

Denti-Cal Clinic Provider Number(s):

Number	Service Site
Number	Service Site
Number	Service Site
Number	Service Site

B. If you are billing under your physician's and/or dentist's provider number, indicate the following:

Provider Number	Provider Name and Title
Provider Number	Provider Name and Title

Pharmacy Number(s), if applicable:

Provider Number	Provider Name and Title
-----------------	-------------------------

FOR EACH PROVIDER LISTED ABOVE, SUBMIT A COPY OF THE WRITTEN AGREEMENT WHICH STATES THAT ANY INCOME DERIVED FROM BILLING UNDER THE PHYSICIAN / DENTIST NUMBER IS CLINIC INCOME.

2. Financial Status: Submit a copy of most recent quarterly or monthly financial statement that includes all corporate debts and incoming funds.

(Agency's Name)

TABLE A
SUMMARY OF
CURRENT BUDGET FROM ALL SOURCES
(As of April 2002)

FUNDING SOURCE (Include Medi-Cal and Other Third Party Revenues)	SUBTOTALS			TOTALS
	Personnel	Operating Expenses	Consultants	
SUMMARY TOTALS	\$	\$	\$	\$

Grand Total

(Agency's Name)

TABLE B
CURRENT PERSONNEL LINE ITEM BUDGET FROM ALL SOURCES
(As of April 2002)

BUDGET CATEGORY PERSONNEL SERVICES	SOURCE OF FUNDS				TOTALS
	State (Specify)	Federal	County	Third Party (Specify)	
TOTAL SALARIES	\$	\$	\$	\$	\$

Grand Total

(Agency's Name)

TABLE C - PAGE 1
PROPOSED IHP BUDGET
FOR FISCAL YEAR JULY 1, 2002 - JUNE 30, 2003

PERSONNEL

PAY PERIOD (CHECK ONE) ☐ Biweekly (26) ☐ Semimonthly (24) ☐ Monthly (12)

POSITION TITLE	(A) FTE Salary Per Pay Period	(B) No. of Pay Periods	(C) % of FTE	(D) % Paid by this Grant	(E) Amount Requested A x B x C x D

TOTAL SALARIES

FRINGE BENEFITS (_____ % of Personnel Costs used [average])

FICA @ _____ %

SUI @ _____ %

WC @ _____ %

TOTAL FRINGE BENEFITS

TOTAL Personnel Services \$

OPERATING EXPENSES

Audit	
Communications	
General Expenses	
Insurance	
Janitorial and Maintenance Services	
Patient Transportation	
Rent (_____ sq. ft. x \$ _____ sq. ft. / mo. = \$ _____ / mo. X _____ mos. X _____ % / State Share)	
Technical Supplies	
Traditional Health / Medicine	
Travel	
Utilities	
Vehicle Operation and Maintenance	
TOTAL Operating Expenses \$	

(Agency's Name)

TABLE C - PAGE 2
PROPOSED IHP BUDGET
FOR FISCAL YEAR JULY 1, 2002 - JUNE 30, 2003

CAPITAL EXPENDITURES

Equipment (List detail below)

(A) Quantity	Description	(B) Unit Cost	(A x B) TOTAL COST
TOTAL Capital Expenditures			\$

OTHER COSTS

Computer Hardware			
Computer Software			
Consulting and Professional Services Total (see breakdown below)			
Subcontractor's Name and Title	Rate of Dollars Per Hour	Total Subcontract Amount	
Staff Training and Continuing Education			
TOTAL Other Costs			\$

INDIRECT COSTS

Indirect Cost: _____ % of

(__ % of [enter cost basis])

TOTAL Indirect Costs \$

TOTAL BUDGET \$

AUTHORIZATION TO BIND CORPORATION AND INVOICE APPROVAL FORM

The Board of Directors of the _____

in a duly executed meeting held on _____

and where a quorum was present, resolved to authorize:

Signature: _____

Date: _____

Name: _____
(Type/Print)

Title: _____

Signature: _____

Date: _____

Name: _____
(Type/Print)

Title: _____

Signature: _____

Date: _____

Name: _____
(Type/Print)

Title: _____

to negotiate and sign State Indian Health Program grant and any invoices that may result.

The undersigned hereby affirms he/she is a duly authorized officer of the Corporation and that the statements contained in this document are true and complete to the best of his/her knowledge. The undersigned further affirms that the applicant accepts, as a condition of the Grant, the obligation to comply with the applicable State and Federal requirements, policies, standards and regulations. The undersigned further affirms that the funds shall be used for delivering primary care medical, dental, and outreach services to program beneficiaries. The undersigned recognizes that this is a public document and is open to public inspection.

Signature: _____ **Date:** _____
(Corporate Officer's Signature)

Name: _____ Title: _____
(Type/Print)

Form Completion Instructions: At least two persons must be authorized to sign clinic invoices. A current authorization form must be kept on file with the State Indian Health Program. If any changes in this authorization occur, the clinic must notify the State Indian Health Program within ten (10) working days in writing. Additional copies of this form are available at <http://www.dhs.ca.gov/ihp>.

All signatures must be in blue ink